Docket No. 512-96-1911

TEXAS STATE BOARD OF PODIATRIC MEDICAL EXAMINERS, PETITIONER V. GARY J. MELLON, D.P.M. LICENSE NO. 0647 RESPONDENT	§ § § § § § §	BEFORE THE TEXAS STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

ORDER OF THE BOARD

Came on for consideration this 6th day of March, 1998, the above-styled and numbered case.

After proper notice was given, the above-styled and numbered case was heard by an Administrative Law Judge, who made and filed a proposal for decision containing findings of fact and conclusions of law. This proposal for decision was properly served on all parties who were given an opportunity to file exceptions and replies as part of the record herein.

The Texas State Board of Podiatric Medical Examiners, after review and due consideration of the proposal for decision, the exceptions, and Responses to the Exceptions and other Motions, arguments and evidence presented, adopts the findings of fact and conclusions of law of the Administrative Law Judge contained in the proposal for decision and incorporates those findings of fact and conclusions of law into this Order as if such were fully set out and separately stated herein. All proposed findings of fact and conclusions of law submitted by any party which are not specifically adopted herein are denied.

IT IS, THEREFORE, ORDERED by the Texas State Board of Podiatric Medical Examiners that **License No. 0647 issued to Gary J. Mellon, D.P.M.** to practice Podiatric Medicine be, and the same is hereby REVOKED.

Witness my hand and seal of office on this the 6th day of March, 1998

By:

W. Preston Goforth, D.P.M.
President, TSBPME

Paul H. Schwarzentraub, D.P.M.
Board Member, TSBPME

Donald Falknor, D.P.M.
Board Member, TSBPME

Teresa Barrios-Ogden, D.P.M.
Board Member, TSBPME

(Voted against)
C. Stanley Churchwell, D.P.M., J.D.
Board Member, TSBPME

Barbara G. Young
Board Member, TSBPME

Jim D. Lummus, D.P.M.
Board Member, TSBPME

Alex Garcia, Jr.
Board Member, TSBPME

DOCKET NO. 512-96-1911

TEXAS STATE BOARD OF	§	BEFORE THE STATE OFFICE
PODIATRIC MEDICAL EXAMINERS,	§	
PETITIONER	§	
VS.	§	OF
GARY J. MELLON, D.P.M.	§	
LICENSE NO. 647,	§	
RESPONDENT	§	ADMINISTRATIVE HEARINGS

PROPOSAL FOR DECISION

The staff of the Texas State Board of Podiatric Medical Examiners (Petitioner) brought this case against a licensee alleging he falsified medical records and his treatment of a diabetic patient with a foot ulcer was below the standard of care for a podiatrist. Petitioner further alleged the podiatrist's license should be revoked and an administrative penalty of $52,500.00 should be imposed. The podiatrist contended the disciplinary action was in violation of the Americans with Disabilities Act, Petitioner did not give proper notice, and the Board lacked jurisdiction to take action. This proposal for decision recommends the podiatrist's license be revoked, but that no administrative penalty be imposed.

I.
PROCEDURAL HISTORY, NOTICE, AND JURISDICTION

The hearing on the merits was held on May 14 - 15, 1997, before Georgie B. Cunningham, Administrative Law Judge, at the Stephen F. Austin State Office Building, 1700 North Congress Avenue, Austin, Texas. Petitioner was represented by Melissa Juarez, Assistant Attorney General. Gary J. Mellon, D.P.M. (Respondent) appeared and was represented by Norman Landa and Mark J. Hanna, Attorneys. Respondent and his attorneys left the hearing shortly after it reconvened on May 15, 1997.[1] The record was left open until June 9, 1997, for the receipt of written closing arguments, at which time it was closed.[2]

Respondent asserted Petitioner's notice was defective, and Petitioner had no jurisdictional basis on which to proceed. Respondent argued Petitioner's complaint cited a violation of Tex. Rev. Civ. Stat. Ann. art. 4570(d)(16), which relates to applications for licenses, instead of Tex. Rev. Civ. Stat. Ann. art. 4573, related to complaints and revocation or suspension of licenses. In its notice letter, Petitioner stated it brought the action under the authority of its enabling statute, Tex. Rev. Civ. Stat. Ann. art. 4567, *et seq*. The complaint specifically cited Article 4573(b) as statutory authority for instituting disciplinary action.

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[1] Respondent actually announced his "withdrawal," but was advised the hearing would continue. For the record, it is also noted that prior to the hearing, Petitioner had scheduled Respondent's deposition four times. Respondent left three of the settings without agreeing to be deposed and did not appear at the other setting.

[2] Both Petitioner and Respondent filed written closing arguments.

The title of Article 4570, "Application for a License," may be a misnomer since Section (d) lists eighteen possible violations by a licensee. Petitioner alleged Respondent's acts were violations of Article 4570(d)(4), (5), and (16) and one of the Board's rules, 22 Tex. Admin. Code §375.2. The hearing notice and complaint met the notice requirements of Tex. Gov't Code Ann. §2001.052(a) by providing a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the particular sections of the statutes and rules involved; and a short, plain statement of the matters asserted. Thus, Respondent's challenge to notice and jurisdiction was overruled.

Respondent further asserted he was mentally ill and the Board violated his rights under the Americans with Disabilities Act by instituting disciplinary action against him. Respondent did not make a prima facie showing he was suffering from a mental condition or specify the particular statutory provisions the Board might be violating. Instead, Respondent produced only a copy of a complaint he had filed with the United States Department of Health and Human Services against the Board. Until such time as the Department issues a ruling or takes other action against the Board, the complaint should be considered merely an allegation.

II.
INTRODUCTION

The following is a brief outline of the facts giving rise to this case, the arguments of the parties, and the pertinent statutory provisions.

A. Background

Respondent holds License No. 647 issued by the Board. He has an office in Duncanville, Texas. From September 30, 1993, through March 1, 1994, [redacted], a diabetic patient, sought medical treatment from Respondent for a blister[3] on the bottom of his right foot. During the first office visit, Respondent took [redacted] medical history, examined the blister, administered a Betadine whirlpool bath, instructed [redacted] to use Betadine ointment on the blister, covered the blister with a sterile gauze pad, and advised him to stay off his foot as much as possible. Thereafter, [redacted] went to Respondent's office on a weekly basis for treatment. During each visit, Respondent or his nurse removed the bandage from [redacted] foot, examined the foot, excised necrotic tissue, administered a whirlpool bath for 20 minutes, excised additional tissue, and applied Betadine ointment and a gauze pad.

When [redacted] awoke on March 1, 1994, he found his right foot was swollen, discolored, and painful, and he was unable to put weight on the foot. During an office visit, Respondent examined [redacted] right foot, drained purulent fluid from it, informed [redacted] he could no longer treat him as a patient, and referred [redacted] to Parkland Memorial Hospital. When [redacted] went to the hospital, he was advised he

[3] The blister was eventually referred to as an ulcer.

should have his leg amputated immediately because it had seven different bacterial growths in it and the tissue was dead. [redacted] was further advised he risked death within two days if he did not have the amputation. [redacted] right leg was amputated four inches below the knee. As of the date of the hearing, [redacted] continued to have pain and problems with the nerves in his right leg.

Following the amputation, [redacted] requested his medical records from Respondent. Respondent refused to provide the records and informed [redacted] he would have to get a court order to get them. On May 25, 1994, [redacted] served Respondent written notice of his intention to pursue a medical liability claim arising from Respondent's treatment. After [redacted] filed a lawsuit on August 3, 1994, Respondent produced the medical records. [redacted] also filed a complaint with the Board resulting in this disciplinary action against Respondent.

B. Petitioner's Position

Petitioner asserted Respondent fabricated laboratory reports and medical records in an attempt to avoid liability for the medical claim and practiced podiatry in a manner that was not consistent with the public health and welfare. Petitioner argued Respondent's conduct was grossly unprofessional and dishonorable because it deceived and defrauded the public. According to Petitioner, it also constituted Respondent's failure to act within the highest plane of honesty, integrity, and fair dealing, as required by rule.

In support of its position, Petitioner presented documentary evidence and the testimony of Allen M. Hymans, the Board's Executive Director and Investigator; [redacted], the patient; William B. Bradbury, D.P.M., an expert witness; and Danielle Brown, custodian of records for Quest Diagnostics, formerly Damon/Metwest Laboratory. The evidence is summarized in Section III of the proposal for decision and set forth in greater detail in the proposed findings of fact.

C. Respondent's Position

Respondent indicated he intended to have Jay D. Lifshen, D.P.M. testify as an expert witness that Respondent's care of [redacted] met the requisite standard of care. He also intended to have four fact witnesses. Gerald A. Schneider, M.D. and Thomas H. Cook, Ph. D. would have testified about his medical condition and treatment and the positive prognosis; Perry H. Peterson, D.P.M. would have testified about his participation in a peer assistance program; and Carl D. Solomon, D.P.M. would have testified as to Respondent's good character and standing in the community. Respondent did not indicate whether he intended to testify. Instead, Respondent presented one document and left the hearing before presenting a direct case. The document is discussed in Section III.

D. Statutory Provisions and the Rule

Petitioner asserted the facts alleged were violations of the podiatry practices act, Tex. Rev. Civ. Stat. Ann. art. 4570(d)(4), (5), and (16) and of the Board's rule, 22 Tex. Admin. Code §375.2(a) and (b). Article 4570(d) lists the following violations:

> (4) Grossly unprofessional or dishonorable conduct, of a character which in the opinion of the board is likely to deceive or defraud the public;
>
> (5) The violation, or attempted violation, direct or indirect, of any of the provisions of this Act ... or any rule adopted under this Act;
>
> (16) The failure to practice podiatry in an acceptable manner consistent with public health and welfare....

Section 375.2(a) provides that the health and safety of the patient shall be the first consideration of the podiatrist and that he shall administer to patients in a professional manner and to the best of his ability. Section (b) of the rule provides that a podiatrist shall conduct his practice on the highest plane of honesty, integrity, and fair dealing.

III.
EVIDENCE

[redacted] testified about Respondent's treatment between September 30, 1993, and March 1, 1994, his leg amputation, and his inability to get his medical records from Respondent without filing a lawsuit. He identified and marked the portions of the progress notes which were false. [redacted] described the progress notes as "supposedly being" his medical record. He explained:

> [T]here was a lot of things in it [the progress notes] that never happened, are untrue. And it seemed like somebody sat down and just composed these at a sitting.

Dr. Bradbury testified about progress notes and the falsification of medical records. He explained that progress notes document a physician's medical treatment of a patient for the following purposes: (1) continued care of the patient, (2) use by other physicians in providing the patient care, and (3) for insurer reimbursement. Progress notes should record what actually occurs during a patient visit. It is not acceptable in the practice of podiatric medicine for a podiatrist to place information in progress notes about acts that did not occur. He further testified that fabrication of laboratory reports places the public health and welfare in danger.

Dr. Bradbury also testified about Respondent's acts, which, in his opinion, constituted a failure to practice within the standard of care required of podiatrists. He addressed Respondent's failure to request x-rays, use alternate therapeutic treatment on a non-healing blister, refer a diabetic patient for treatment of his diabetes, refer a

patient with a non-healing ulcer to a wound care clinic, or take culture and sensitivity tests. He also testified about placing an ulcerated foot in a dirty whirlpool and not padding the foot to relieve pressure.

Mr. Hymans verified that the Board had received the present complaint, notice had been provided Respondent, and the parties had attempted to resolve the matter informally. He also confirmed that the Board had issued Agreed Board Order No. 91-11-003 dated June 5, 1991, suspending Respondent's license for two years beginning July 1, 1991, with the suspension probated except for thirty days. The previous settlement agreement arose from allegations Respondent had changed official records. Respondent agreed to notify the Board of his hospital and outpatient surgery center affiliation, to complete 16 hours of continuing medical education, and to abide by the law during the period of suspension. The order acknowledged that Respondent did not admit any wrongdoing nor did the Board find any wrongdoing as part of the agreed settlement.

Ms. Brown authenticated three laboratory reports from Damon/Metwest Laboratory on culture and sensitivity tests Respondent submitted on June 2, 3, and 6, 1994. She testified that each specimen had a unique laboratory number and requisition number. The June tests were purportedly [redacted] specimen, although Petitioner had already established that [redacted] had his foot amputated on March 1, 1994, was no longer Respondent's patient in June 1994, and had sent Respondent notice of his intention to pursue a medical liability claim. Ms. Brown also testified that three other documents purportedly showing [redacted] test results on September 30 and November 29, 1993, and January 26, 1994, were not Damon/Metwest Laboratory reports. All of these other documents, produced by Respondent while [redacted] lawsuit was pending, had the same laboratory number and negative test results as the culture and sensitivity test Respondent submitted on June 3, 1994.

While Respondent strongly challenged the admissibility of the evidence, he presented only one document as direct evidence to refute Petitioner's evidence. He offered a copy of the settlement agreement in the lawsuit [redacted] filed against him in Dallas County, Texas. On December 6, 1994, [redacted] agreed to release the medical liability claim, with prejudice, against Respondent for $500,000.00 and court costs. Respondent denied liability, and [redacted] agreed not to file any additional claim.

IV.
DISCUSSION AND RECOMMENDATION

Despite Respondent's attempt to deny liability through production of the settlement agreement, the complaint [redacted] filed with the Board is not a civil lawsuit claim. [redacted] made it known in his testimony that he will not benefit from filing the complaint. Instead, he lost time and money by having to travel to Austin for the hearing. Moreover, Mr. Hymans explained that Petitioner is required by statute to investigate complaints and take action when necessary. Petitioner's disciplinary action was brought under the police power of the state independent of the civil action

brought by [redacted]. The parties and the outcomes of the two proceedings are entirely unrelated. Furthermore, it is common practice for lawsuits to be resolved informally without any admission of liability. The informal resolution of [redacted] lawsuit does not affect this disciplinary action.

Petitioner presented clear and convincing evidence that Respondent violated the podiatric medical practices act and the Board's rules by falsifying [redacted] progress notes, attempting to create laboratory records, and by failing to treat [redacted] in the standard of care consistent with public health and welfare. The evidence presented was frequently corroborated through the testimony of another witness or by documentary evidence. Respondent did not deny or present any evidence to refute the allegations that he falsified the laboratory reports and progress notes and failed to follow an acceptable standard of care for a podiatrist. Based on the evidence received, the Administrative Law Judge recommends the Board revoke Respondent's license to practice podiatry in this state.

In its complaint, Petitioner asked for license revocation. In the alternative, Petitioner asked for license suspension of no less than six months or "other appropriate means of discipline." In its written closing argument, Petitioner recommended license revocation and the imposition of an administrative penalty of $52,500.00. Article 4567e of the act enables the Board to impose an administrative penalty in an amount not to exceed $2,500.00 for a violation of the act or a rule adopted pursuant to the act. Each day a violation occurs is a separate violation for purposes of imposing a penalty.

Petitioner asserted Respondent's conduct violated at least eleven statutory provisions and ten Board rules. The statute provides that the amount of the penalty shall be based on six enumerated factors. Petitioner did not address the matter of an administrative penalty at the hearing nor did it address the six factors to be considered in assessing a penalty in its written closing argument. Moreover, Petitioner did not show it has authority to impose an administrative penalty along with license revocation. Therefore, the Administrative Law Judge does not recommend the imposition of an administrative penalty in addition to the recommendation of license revocation.

V.
FINDINGS OF FACT

1. Gary J. Mellon (Respondent), D.P.M., holds License No. 647 issued by the Texas State Board of Podiatric Medical Examiners (the Board).

2. On April 25, 1995, the Board's staff (Petitioner) sent Respondent notice a complaint had been filed against him.

3. On May 18, 1995, Petitioner sent Respondent notice an informal conference had been scheduled to provide Respondent an opportunity to resolve the complaint before proceeding to a hearing.

4. On April 22, 1997, Staff sent notice of the hearing to Respondent. The hearing notice contained a statement of charges, of the statutory provisions and rules, and of the time and place of the hearing.

5. On September 30, 1993, [redacted] sought medical treatment from Respondent for a blister on the bottom of his right foot.

6. On September 30, 1993, Respondent took [redacted] medical history, examined the blister, gave his foot a Betadine whirlpool bath, instructed [redacted] to use Betadine ointment on the blister, covered the blister with a sterile gauze pad, and advised him to stay off his foot as much as possible.

7. Between September 30, 1993 and March 1, 1994, [redacted] went to Respondent's office for treatment approximately once per week.

8. During each treatment between September 30, 1993 and March 1, 1994, Respondent or his nurse removed the bandage from [redacted] foot, examined the foot, excised necrotic tissue, administered a whirlpool bath for 20 minutes, excised additional necrotic tissue, and applied Betadine ointment and a gauze pad.

9. Upon awakening on March 1, 1994, [redacted] found his right foot was swollen, discolored, and painful, and he was unable to step on the foot.

10. On March 1, 1994, Respondent examined [redacted] right foot, drained purulent fluid from the foot, informed [redacted] he could no longer treat him as a patient, and referred [redacted] to Parkland Memorial Hospital.

11. On March 1, 1994, physicians at Parkland Memorial Hospital determined [redacted] risked death within two days because his right leg had seven different bacterial growths in it and the tissue was necrotic. [redacted] leg was amputated four inches below his knee.

12. As of the date of the hearing, [redacted] continued to have pain and problems with his nerves in his right leg.

13. Following the amputation, [redacted] requested his medical records from Respondent.

14. Respondent refused to provide the medical records and informed [redacted] he would have to get a court order to get the records.

15. On May 25, 1994, [redacted] served Respondent with written notice sent by certified mail, return receipt requested, that he was filing a health care liability claim arising from the medical care he received from Respondent.

16. On May 26, 1994, Respondent's agent received the notice specified in Finding of Fact No. 15.

17. On August 3, 1994, [redacted] filed a civil lawsuit against Respondent.

18. While the lawsuit was pending, Respondent provided [redacted] a copy of his progress notes purportedly documenting [redacted] treatment between September 30, 1993, and March 1, 1994.

19. Respondent's progress notes show he administered culture and sensitivity tests to [redacted] on September 30, 1993, November 29, 1993, and January 26, 1994.

20. While the lawsuit was pending, Respondent provided [redacted] a copy of Damon/Metwest Laboratory (now Quest Diagnostics) Report No. 01417174-2, dated October 2, 1993, showing the results of Respondent's culture and sensitivity study of [redacted] foot on September 30, 1993.

21. While the lawsuit was pending, Respondent provided [redacted] a copy of Damon/Metwest Laboratory Report No. 01417174-2, dated December 1, 1993, showing the results of Respondent's culture and sensitivity study of [redacted] foot on November 29, 1993.

22. While the lawsuit was pending, Respondent provided [redacted] a copy of Damon/Metwest Laboratory Report No. 01417174-2, dated January 28, 1994 showing the results of Respondent's culture and sensitivity study of [redacted] foot on January 26, 1994.

23. The laboratory reports specified in Findings of Fact Nos. 20-22 showed negative results for bacterial growth in [redacted] foot.

24. On June 2, 1994, Respondent submitted a culture and sensitivity study purportedly from [redacted] right foot ulcer to Damon/Metwest Laboratory via requisition No. ZZZ66666-1.

25. On June 2, 1994, Damon/Metwest labs assigned identification No. 01413422-5 to the specimen referenced in Finding of Fact No. 24.

26. On June 3, 1994, Respondent submitted a culture and sensitivity study purportedly from [redacted] right foot ulcer to Damon/Metwest Laboratory via requisition No. ZZZ54478-7.

27. On June 3, 1994, Damon/Metwest Laboratory assigned identification No. 01417174-2 to the specimen referenced in Finding of Fact No. 26.

28. On June 6, 1994, Respondent submitted a culture and sensitivity study purportedly from [redacted] right foot ulcer to Damon/Metwest Laboratory via requisition No. ZZZ46698-3.

29. On June 6, 1994, Damon/Metwest labs assigned identification No. 01422384-4 to the specimen referenced in Finding of Fact No. 28.

30. Damon/Metwest Laboratory reported negative results for bacteria from specimen No. 01417174-2.

31. Damon/Metwest Laboratory reported positive results for bacteria from specimen Nos. 01413422-5 and 01422384-4.

32. At Damon/Metwest Laboratory each specimen has a unique laboratory number and a unique requisition number.

33. The three laboratory reports specified in Findings of Fact Nos. 20 - 22 are not from Damon/Metwest laboratory.

34. Damon/Metwest Laboratory does not have records of any laboratory tests for [redacted] other than the June 1994 tests.

35. [redacted] right leg was amputated approximately three months before Respondent submitted the culture and sensitivity studies purportedly from [redacted] right foot to Damon/Metwest laboratory in June 1994.

36. [redacted] was no longer Respondent's patient in June 1994.

37. Respondent did not perform any culture and sensitivity tests on [redacted] between September 30, 1993 and March 1, 1994.

38. Modifying a medical record and falsifying a culture and sensitivity report endangers a patient.

39. It is below the standard of care for a podiatrist to falsify a culture and sensitivity report.

40. Respondent's progress notes dated September 30, October 6, October 11, and October 29, 1993, indicate he prescribed an x-ray for [redacted] foot ulcer at Midway Park Medical Center.

41. Respondent did not prescribe an x-ray for [redacted] between September 30, 1993, and March 1, 1994.

42. A podiatrist needs an x-ray as a baseline when treating the foot of a diabetic patient.

43. Without an x-ray, a podiatrist cannot determine whether bacteria have invaded deeper tissue, tendons, or bone.

44. It would be reasonable for a podiatrist to take an x-ray of a diabetic patient's foot within one to four weeks of beginning treatment.

45. Respondent's progress notes on October 29, November 23, and December 13, 1993, and January 26 and March 1, 1994, reflect that he prescribed an antibiotic for [redacted]

46. Respondent did not prescribe an antibiotic for [redacted] between September 30, 1993, and March 1, 1994.

47. Respondent's progress notes on February 8, February 15, February 22, and March 1, 1994, indicate he referred [redacted] to Parkland and St. Paul Medical Center for contact casting and growth hormone topical programs and to Presbyterian Hospital for a wound care clinic.

48. Respondent did not refer [redacted] for contact casting, growth hormone topical programs, or to a wound care clinic between September 30, 1993, and March 1, 1994.

49. Respondent's progress notes of December 20 and December 29, 1993, and January 26, February 2, February 8, February 15, and February 22, 1994, indicate he referred [redacted] for orthotics and special shoes.

50. Respondent did not advise [redacted] to get orthotic shoes until March 1, 1994.

51. Respondent's progress notes indicate [redacted] never had his ulcer bandaged when he arrived for an examination between September 30, 1993, and March 1, 1994.

52. Respondent consistently had a bandage on his right foot ulcer between September 30, 1993, and March 1, 1994.

53. Respondent's progress notes of October 2, November 23, November 29, December 20, and December 29, 1993, and January 26, February 8, and February 15, 1994, indicate he observed necrotic tissue within [redacted] foot ulcer.

54. Necrotic tissue within a foot ulcer indicates the presence of an infection in the tendon, ligaments, and the bone.

55. On September 30, 1993, [redacted] informed Respondent he was diabetic.

56. Respondent's progress notes dated September 30, 1993, show [redacted] medications included 124 units of insulin once daily.

57. As of September 30, 1993, [redacted] actually took 24 units of insulin once daily.

58. Between September 30, 1993, and March 1, 1994, [redacted] was not under the care of a physician for his diabetes.

59. Respondent did not refer [redacted] to a physician to monitor or treat [redacted] diabetes.

60. A podiatrist should refer a diabetic patient not currently under a physician's care for the treatment of his diabetes when he has a non-healing ulcer.

61. During at least three of [redacted] foot ulcer treatments between September 30, 1993 and March 1, 1994, Respondent's whirlpool tub was covered with a dirty film.

62. After [redacted] complained about the condition of the whirlpool tub, Respondent's nurse cleaned the tub with Betadine.

63. It is not within the standard of care for a podiatrist to use a whirlpool tub with a film to treat a foot ulcer.

64. Respondent failed to provide treatment to [redacted] that a reasonably prudent podiatrist would have administered in the same circumstances.

65. Progress notes document a physician's medical treatment for continued care of a patient, for use by other physicians in providing the patient care, and for insurer reimbursement.

66. Other physicians rely on the progress notes of previous physicians.

67. Progress notes should record what occurs during a patient visit.

68. It is not acceptable in the practice of podiatric medicine for a podiatrist to place information in progress notes about acts that did not occur.

69. If clinical symptoms indicate an infection might be present, it is within the standard of care for a podiatrist to take a culture and sensitivity test of an ulcer.

70. It is not outside the standard of care for a podiatrist to take a culture and sensitivity test of an ulcer even without evidence of infection since bacteria may not be visible.

71. It is within the standard of care for a podiatrist to recommend alternative therapies such as a prescription shoe, shoe inserts, or contact casting for a patient with a foot ulcer to relieve pressure from the ulcer.

72. It is within the standard of care for a podiatrist to try alternative therapies for a diabetic patient if his foot ulcer has not healed within three weeks of beginning care.

73. It is within the standard of care for a podiatrist to submit a culture and sensitivity test to a laboratory the same day it is taken from a patient.

VI.
CONCLUSIONS OF LAW

1. The Texas State Board of Podiatric Medical Examiners has jurisdiction over this matter, pursuant Tex. Rev. Civ. Stat. Ann. art. 4567 *et seq*.

2. The State Office of Administrative Hearings has jurisdiction to conduct the administrative hearing in this matter and to issue a proposal for decision containing findings of fact and conclusions of law, pursuant to Tex. Rev. Civ. Stat. Ann. art. 4567e and Tex. Gov't Code Ann. ch. 2003.

3. Notice of the hearing was provided as required under the Administrative Procedure Act, Tex. Gov't Code Ann. §§2001.051, 2001.052, and 2001.054 and 22 Tex. Admin. Code §377.18.

4. Respondent has exhibited grossly unprofessional or dishonorable conduct in violation of Tex. Rev. Civ. Stat. Ann. art. 4570(d)(4).

5. Respondent has failed to practice podiatry in an acceptable manner consistent with the public health and welfare as prohibited by Tex. Rev. Civ. Stat. Ann. art. 4570(16).

6. Respondent failed to administer to a patient in a professional manner, as required by 22 Tex. Admin. Code §375.2(a).

7. Respondent failed to conduct his practice on the highest plane of honesty, integrity, and fair dealing, as required by 22 Tex. Admin. Code §375.2(b).

8. Based on Conclusions of Law Nos. 6 and 7, Respondent has violated a Board rule, as prohibited by Tex. Rev. Civ. Stat. Ann. art. 4570(d)(5).

9. Based on the foregoing Findings of Fact and Conclusions of Law, the Board should revoke the license of Gary J. Mellon, D.P.M.

SIGNED this 17th day of July, 1997.

Georgie B. Cunningham

GEORGIE B. CUNNINGHAM
Administrative Law Judge
State Office of Administrative Hearings

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